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Medical Release Form

Attending Physician (s)

Name (s)

Phone #

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau or other organization, institution or person that has any records or knowledge of me or my health or that of my family listed on this form to give to my employer or its insurers any such information. A photographic copy of this authorization shall be as valid as the original.

Signature _____ Date _____

Printed Name _____